NC DHHS PRTF MEDICAID AUDIT TOOL
2011

PARENT COMPANY:			**AUDIT DATE:**
PROVIDER NAME:			**NAME:**
PROVIDER #			**MEDICAID #:**
CONTROL #:	**DOB/AGE:**		**SERVICE DATE:**
CASE MANAGEMENT:			**RECORD #:**

RATING CODES:	**O = No** **2 = partially met** **4 = Yes**	**6 = No service note** **7 = Unable to identify service provider**	**8 = Repaid** **9 = NA**	**RATING**

AUTHORIZATIONS (Use rating of "4" or "0" for Q 1-5	
1. Was an authorization in place covering this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**	
2. Is there a valid certificate of need (CON) for the service billed? **a. If NOT MET list dates FROM:_____ TO:_____**	
3. Is the date of service covered by a valid treatment plan? **a. If NOT MET list dates FROM:_____ TO:_____**	
4. Is there evidence that discharge planning began on the day of admission? **a. If NOT MET list dates FROM: _____ TO: _____**	
5. Is there evidence that the child met the eligibility requirements for admission or continued stay? **a. If NOT MET list dates FROM: _____ TO: _____**	
TREATMENT PLAN / SERVICE DOCUMENTATION (Use Likert Scale See Instructions): **(Use rating of "4", "2" or "0" for Q 6-14 and "4" or "0" for Q15—or ratings of 6, 8, or 9 as applicable)**	
6. Is the treatment plan individualized per person? **a. If NOT MET list dates FROM:_____ TO: _____**	
7. Is there evidence of involvement of the family or legally responsible person in the development of goals, treatment process, and discharge plans?	
8. Does the treatment plan address problems/diagnoses identified in the assessment that impact the child or adolescent's ability to function in a less restrictive setting i.e. substance abuse, sexual acting out?	
9. Does the documentation include a valid signature within the designated time frame by the person who delivered the service?	
10. Is the family or legally responsible person actively involved in the treatment as required in the plan, or is there evidence of active, ongoing efforts being made to involve them?	
11. Does the service note(s) relate to goals listed in the treatment plan?	
12. Does the documentation reflect treatment for the duration of service?	
13. Does the service note reflect assessment of progress toward goals?	
14. Are the service notes individualized per person?	
15. Did the psychiatrist provide weekly consultation to review medications with this child/adolescent? **a. If NOT MET list dates FROM: _____ To: _____**	
QUALIFICATIONS / SUPERVISION / RECORD CHECKS: (Use a rating of "4" or "0" for Q 16-20)	
16. Is there evidence that staff is qualified (demonstrates knowledge, skills and abilities per NC Rule and Policy and provider policy) for the service provided? **a. If NOT MET list dates FROM:_____ TO:_____**	
17. Is there evidence the individual had Alternative to Restrictive Intervention training prior to the date of service? **a. If NOT MET list dates FROM:_____ TO:_____**	
18. a. Is an individualized supervision plan in place for paraprofessional and/or AP staff? **b. Is the plan implemented?** **c. If "a or b" is NOT MET list dates FROM:_____ TO:_____**	**a.** **b.**
19. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service, prior to employment? *[Hired prior to 3/24/05]* **b. Was the appropriate Criminal Record check requested prior to this date of service? *[hired on or after 3/24/05]*** **c. If "a or b" is NOT MET list dates FROM:_____ TO:_____**	**a.** **b.**
20. Did the provider agency complete a NC Health Care Personnel Registry check prior to this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**	

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COMMENTS:

AUDITOR:	LME: